UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

CANCIDAS (caspofungin acetate)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext.and options_____Fax#_____

Pharmacy_____Pharmacy phone#_____

Diagnosis_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY

CRITERIA FOR:

- Age 18 and older
- **Diagnosis of Invasive Aspergillosis Infection**
- Failure on Amphotericin B ***OR***
- Have documented lab culture showing aspergillosis is not sensitive to amphotericin B or itraconazole

CRITERIA FOR:

- Age 18 and older
- **Diagnosis of Esophageal Candidiasis, intra-abdominal abscess, peritonitis or pleural space infections**
- Cultures identifying Candida**.**

ALSO APPROVED FOR: Prophylaxis for severely immuno-compromised bone marrow transplant patients with severe graft vs. host disease.

AUTHORIZATION:

3 months

RE-AUTHORIZATION:

3 months with current lab culture and continuing symptoms

Child with cancer or bone marrow transplant post-hospital receives as needed.

Adult with bone marrow transplant, post-hospital receives as needed.

7/7/6